



The CHILD

CHILDREN'S BUREAU • U. S. DEPARTMENT OF LABOR

-
- Toward Rehabilitating Crippled Children
 - Hospital Nurseries for Newborn
 - Can a Migratory Child Go To School?

The CHILD

MONTHLY BULLETIN

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CONTENTS

	Page
Unfinished Business	66
The Road Toward Rehabilitation. <i>Helen J. Almy</i> ...	67
School Doors Begin to Open to the Children of Migratory Farm Workers. <i>Ione L. Clinton</i>	71
University Hospital Prepares to Give Better Care to Newborn Babies.....	75
C. B. News Notes.....	76
Ten Years of Progress in Reducing Maternal and Infant Mortality Rates in the United States, 1933-43. <i>Marjorie Gooch</i>	77
Children Around the World	84

The photograph on the cover is by Frank H. Ubhaus

U. S. DEPARTMENT OF LABOR
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CHILDREN'S BUREAU
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UNFINISHED BUSINESS

"INFANT MORTALITY," an eminent British physician once said, "is the most sensitive index we possess of social welfare."

For the first time in the history of the country, it is now possible to measure in comparable figures a decade of gains in saving the lives of mothers in childbirth and of babies during their first year of life. Marjorie Gooch tells the statistical story on pages 77 to 83.

On their face, the figures appear to give an optimistic picture. In this 10-year period, the Nation has achieved a 60-percent drop in maternal mortality and a 31-percent drop in infant mortality.

Good as this record is, it is not good enough for a Nation with the scientific and technical know-how that we possess in preventing and curing illness and injury, and with the economic resources we have for developing and providing top-quality services and facilities for healing and for the saving of human lives.

Over 7,000 mothers died in 1943 from childbearing. Several thousand of these mothers might have been saved. For proof: If every State had had as good a record as the best State—Minnesota—had in that year, nearly 3,000 mothers would not have died.

Over 100,000 babies in 1943 died in their first year of life. If every State had had as good a record as the best State—Connecticut—had in that year 31,000 babies would have been saved.

No one attack will win the battle against this needless loss of life. Gains must be made along a broad front: Improvement in environmental sanitation, safer water and milk supplies, better education of parents in infant care and in the safe preparation of food; assurance of medical care for all mothers throughout pregnancy, at childbirth, and for 6 weeks after birth; assurance of preventive medical care for babies and

skilled treatment for them when they become ill.

Two hundred thousand mothers are still delivered in a year without any medical supervision.

A baby's first day of life is his most critical and should be spent in a hospital. While 87 percent of the urban babies are born in hospitals, only half the rural babies are born there. Seventy-seven out of every 100 white babies are born in hospitals, but only 33 out of every 100 nonwhite babies are born there.

One out of three counties has no public-health nurse to advise mothers in their homes on good care for themselves and their babies.

Three out of five counties have no service from full-time public-health units.

A great expansion in the supply of physicians, public-health and hospital nurses, in hospitals and health centers is needed if we are to save the lives of more mothers and babies.

If all mothers had the specialized care from obstetricians that is now available to mothers in big cities, we would need 4,865 more obstetricians.

Sixty percent of our children under 15 are in places of less than 10,000 population where only 4 percent of our pediatricians practice.

These are only some indicators of the unfinished business the Nation has in its great task of building the greatest possible safeguards around the birth of every American citizen. But they point to specific, obtainable objectives.

Until the greatest medical and health skills of which we are capable are made available to all children, regardless of where they live or live or their race, or their economic situation, how can we be content?

Martha M. Eliot

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Associate Chief, Children's Bureau

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THE ROAD TO REHABILITATION

Good teamwork by professional workers helps crippled children to lead normal lives

by HELEN J. ALMY

Chief of Public Health Social Work, Massachusetts Department of Public Health

PHYSICIAN, medical-social worker, public-health nurse, physical therapist, teacher, rehabilitation agent—each of these contributes professional skill in helping the crippled child to become a healthy, self-supporting adult. If these skilled workers can begin to help the child early enough, their teamwork may obviate the need for formal rehabilitation measures.

The children whose stories are given here benefited from what might be called "prehabilitation" services, which help to prevent crippling conditions and crippling emotional attitudes. The care was provided through Services for Crippled Children, Massachusetts Department of Health, in cooperation with workers on the staffs of community agencies.

Johnnie would have grown up handicapped; but good professional teamwork prevented crippling

A baby with clubfoot needs to be taken by his parents to the doctor at once. If they accept the instructions that are given them and cooperate with the doctor, the nurse, and the physical therapist in carrying out the treatment prescribed, the condition can usually be corrected so that no handicap results.

Johnnie, a baby born with two clubfeet, was not so easily helped. His parents were poor and ignorant. Their home was crowded, and a new baby was born almost yearly. The family lived in a small town. Johnnie's clubfeet were noticed by the doctor and the nurse at a general clinic where the mother had taken him on account of an eye condition. The clinic doctor told her to take him to the crippled children's

diagnostic clinic nearest their home for further examination. When she failed to take him there, the medical-social worker at the general clinic communicated with the medical-social worker in the district health office. This worker and the local public-health nurse persuaded the parents to take Johnnie to the crippled children's clinic. The orthopedic surgeon recommended that Johnnie's feet be operated on.

Then it was the task of the various workers to persuade Johnnie's father and mother to let him be taken to a hospital 50 miles away. The orthopedic surgeon, the clinic medical-social worker, and the public-health nurse explained the situation to the baby's parents, who finally agreed to have the two operations performed at the distant hospital.

The next problem was how to get proper follow-up care for Johnnie after each of the operations. Both the medical-social worker and the public-health nurse felt that good care in the baby's own home would be impossible, and that an arrangement should be made for convalescent care in a foster home near the hospital. Again the nurse who had helped the parents to agree to the operations was called upon. She discussed with the parents the plan for a foster home, and she was successful in getting them to consent. The medical-social worker then enlisted the cooperation of a child-placing agency in making the plans for foster-home care.

After each of the operations Johnnie stayed at the foster home under the close supervision of a nurse and a physical therapist. All the time he was away from home the medical-social worker, the pub-

lic-health nurse, and the worker for the child-placing agency cooperated in working with the family to make sure that Johnnie's place as a member of the family was not jeopardized.

Johnnie is now expected to grow up without a crippling condition. His experience shows that not only medical and surgical care, nursing, and physical therapy were needed for his physical restoration but also social planning. In spite of the excellent medical and surgical facilities that existed, Johnnie would not have had the benefit of them without the joint work of all the members of the medical team. The home factors would have been too great an obstacle to success.

Peter was on the way to becoming delinquent. Now he is a promising schoolboy

Sometimes the child's crippling is not so serious a problem as the behavior accompanying it, and any successful plan for helping him must include not only orthopedic care but also recognition and treatment of the causes of his behavior.

Peter, 12 years old, had a conspicuous deformity. From birth one leg had been very much shorter than the other. He wore an orthopedic brace, and got around well. Peter was receiving clinic supervision, with the possibility of surgical treatment at some future time.

The public-health nurse in the community where Peter lived learned that his behavior was causing serious difficulty at home and at school. He was defying relatives and teachers, and he was lying and stealing.

The nurse knew that Peter did not have either his father or his

mother living with him and suspected that his troublesome behavior was related to his lack of a real family as well as to his crippling. She asked the medical-social worker to look into the situation.

The medical-social worker learned from the local physician and the nurse that Peter's mother had deserted the boy and his father when Peter was 3 years old, and that his father had boarded him with relatives and had gone to live in another town. Peter's behavior difficulties had begun about the time when his father had stopped paying board for him and visiting him and had even stopped writing to him. Peter obviously felt that he had lost status, both at home, where he heard his relatives blaming his father, and at school, where he needed to be able to talk about his dad like the other boys.

It was obvious that some one must help Peter revive the bond with his father and in other ways build up his sense of security so as to get over his difficulties. With the cooperation of a children's agency, the worker arranged to have Peter go to a child-guidance clinic, where he was encouraged to express some of his feelings and to realize that in spite of his handicap he could hold his own at school.

The father was given a better understanding of Peter's needs and was helped to realize how much he could do to benefit his boy. It was impossible for the father to make a home for Peter, but he did begin to write to him, to pay board for him, and to send him occasional presents.

Peter's attitude at home and at school improved. His stealing and lying stopped. Moreover, during his attendance at the child-guidance clinic it was discovered that he was unusually bright and gifted. In a few years he could be expected to make use of vocational-rehabilitation services with marked success.

It is impossible to know how much of Peter's behavior trouble resulted from his crippling condition and how much was connected with his father's desertion and would have been present, handicap or no handicap. His physical handicap no doubt was partly responsible

for his feeling that he was not wanted. And the idea that he was not wanted, along with the fact that he was different from other children, had dominated his attitude at home and at school.

Margaret is handling her handicap better now that she has help with her emotional attitude toward it

Sometimes the feeling of being unwanted or different dominates the patient's mind out of all proportion to the severity of the handicap.

Margaret, at 17, had a slight curvature of the spine, which was hardly noticeable when she was dressed. Yet she believed that everyone was staring at her "deformity."

Margaret's extreme timidity and unwillingness to make social contacts attracted the attention of the medical-social worker at a crippled children's clinic. The medical-social worker felt that Margaret's attitude indicated deep-seated problems that needed psychiatric attention. The clinic physician agreed and advised referral to a psychiatrist.

It then became the job of the medical-social worker to get Margaret to understand the need for this kind of help and to want it. But when the social worker first suggested to the girl that she go to a new doctor, who, as the worker phrased it, "might help her to understand better her feeling about her back," Margaret's response was, "If he will make my back straight I will go to him."

After a number of talks with the worker, however, the girl began to feel that it might be good to talk with this new kind of doctor who would help her to understand herself better. She kept her appointment with the psychiatrist and was able to benefit from his treatment. Gradually she showed more courage and willingness to join in social activity.

In preparing the way for Margaret's acceptance of the special services of the psychiatrist, the medical-social worker provided a service that is frequently necessary when the real problem is not so much the crippling condition as the patient's feeling about it.

A LONG STAY IN THE HOSPITAL isn't breaking up Teddy's school career too much. The public schools in his city assign a teacher to this hospital, and all the children who are able to do lessons can keep up with some of their school work.

Photograph by Frank H. Uehaus



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It often happens that a patient does not understand the need for the physician's recommendation. Such a patient does not follow the recommendation merely because it has been made or because an appointment has been obtained. He may need much explanation from the medical-social worker, and an opportunity to discuss his feelings, before he can make good use of the service recommended.

All the members of the medical team share responsibility for recognizing and considering social factors, and all contribute to an understanding of the individual patient. It is the medical-social worker, however, who is expected to take the primary responsibility with regard to the patient's social needs and to initiate planning for them. Her training has been especially concentrated upon understanding the social and emotional factors related to illness and physical handicap.

The problems of the child or young adolescent in relation to physical restoration and later rehabilitation often involve the problems of his father and mother. The attitudes of the child's parents frequently play an important part in his adjustment to a handicap. Parents who are overanxious may stimulate the child to do too much, and those who are oversolicitous may allow, or cultivate in him, an attitude of overdependence. Other parents take little interest in their child and neglect him.

If the mother is overburdened, sometimes social resources in the community can be utilized to get financial assistance or housekeeping service, or to place the child under temporary foster-home care, as was done for Johnnie, the baby with clubfeet.

Sometimes, however, an oversolicitous attitude in the mother, or her lack of interest in the child, may be symptoms of real problems within herself. She may have a feeling of guilt, thinking perhaps it is her fault that the child is crippled. Or she may be full of self-pity because of the restrictions and deprivations that the care of the crippled child has imposed upon her. Or there may be marital difficulties or other family friction.

In such cases an agreement is

sometimes made by the nurse or the physical therapist and the medical-social worker for cooperative work. Under this arrangement the nurse or physical therapist works primarily with the child while the medical-social worker may center her attention on the mother or on the other members of the family. Such cooperative service can be very successful if the workers plan and work closely together.

If the mother finds in the medical-social worker a person who is especially interested in her, some one with whom she can talk about her problems, she is likely to be released from some of her tensions and be able to take a more relaxed and wholesome attitude toward the child. As a result the child will have a better chance to grow up psychologically, to become emotionally independent, and to be able to use rehabilitation services when the time comes.

Thus far stories of what might be called "prehabilitation" have been discussed. Two stories will now be presented in which the early steps are followed by successful rehabilitation in the more technical sense of the word. For each of these stories a patient with severe structural scoliosis has been chosen—patients for whom long and repeated periods of hospital care were necessary.

Mike has a straight back and a hopeful future now owing to good teamwork

Mike was 16 when he was referred to a crippled children's clinic. He had a severely deformed back, and he was extremely sensitive about it.

His father and mother were foreign-born and had difficulty both in understanding and speaking English. They had a good deal of Old World fear and suspicion of hospitals, and they would not hear of having the spinal operation performed that the orthopedic surgeon at the clinic recommended. The first job of the clinic workers therefore was to persuade the parents to consent to the operation. This was a difficult task. After some time they said they would consent if the doctor would guarantee a cure. This was a step forward, but it was clear that many additional steps were needed.

The clinic doctor patiently gave

the boy and his parents explanations of how much and how little an operation might do. And the physical therapist and the nurse did their part with continued and detailed explanations. Questions and more questions were asked and answered. The medical-social worker, fortunately able to talk with the parents in their own language, had many interviews with them and also with Mike. Sometimes she went to their home in the evening so as to be sure to see the father.

All this took almost 2 years, for the parents, ignorant and fearful, had great difficulty in coming to a decision. At last Mike himself was won over, and after a while his father and mother also agreed to having the operation performed.

At the time Mike was admitted to the hospital, the clinic medical-social worker sent a social summary of his case to the hospital social worker, to help her make the circumstances of the case clear to the physicians and others responsible for his hospital care. The sharing of information between the diagnostic clinic and the hospital can materially help the patient's adjustment to the hospital, especially when there has been resistance to hospitalization.

Mike's hospital career was a great success. The physician saw to it that he was placed near a boy who had already had the type of operation that Mike was to have, and this boy's experience greatly reassured him. Mike made friends among the hospital personnel. A teacher assigned by the local public schools to the hospital gave him lessons.

After a successful operation Mike went home and made a good adjustment there. A home teacher continued his lessons until he was able to return to school. His good adjustment at home was undoubtedly contributed to by the social experience at the hospital—the contacts there with the friendly nurses, doctors, and teacher.

Mike's straight back is a miracle for him and for his family. He tried for the Navy, showing that he felt he was no longer handicapped. He was rejected, to be sure, but he continued to think of himself as a whole man, and he longed to do war work.

Now, a year and a half after his operation, he has a job in the Navy

Yard as apprentice electrician. It is the nearest thing to his ambition—being in the Navy. He seems truly rehabilitated.

Helen is now a self-supporting person instead of a crippled dependent

Another patient with a severely deformed back, whom the State crippled children's agency saw through to successful rehabilitation, was a girl named Helen, who did not come to the attention of the diagnostic clinic until she was 18 years old—almost too late. At that time she was a very lame, crooked little person, with an alert, attractive face and a friendly manner. The orthopedic surgeon at the clinic predicted that unless treatment was provided promptly her legs might become paralyzed.

Conditions in her home were bad. Her mother was dead, and her father was alcoholic and was irregularly employed. She had four younger brothers. Helen was trying to keep house for this family with only casual help and supervision from an aunt living nearby. In spite of all these difficulties, there was a strong family affection.

Helen and her family accepted the doctor's recommendation that an operation should be performed, and she was brought to one of the Boston hospitals.

From the medical-social worker's report the physician realized that proper supervision and follow-up care could not be given Helen in her own home, and therefore convalescent care was arranged in a home in Boston.

While Helen was at the hospital and the convalescent home the public-health nurse received reports on her progress from the medical-social worker and kept the family informed.

After going home Helen resumed her heavy home duties too soon; whereupon the medical-social worker made arrangements for her to live for a while away from home at a special school. In her absence the aunt looked after the younger children, and the public-health nurse continued to visit the home for general oversight.

Helen had expressed a desire to become a beauty-shop operator, and so the worker referred her to the district representative of the State vocational-rehabilitation services, who arranged for the training. Thus the young girl learned that she could support herself.

Temporarily Helen took a job in a plant producing war materials, but she expects to return to the beauty-shop work for which she has been specifically trained.

To carry out the various steps of medical care, convalescence, schooling, vocational rehabilitation for Mike and Helen, many professional people contributed. First, of course, was the physician. But the other clinic personnel, the health and welfare workers in the local communities, the hospital and convalescent-home personnel and the rehabilitation workers all played important parts. The chief role of the medical-social worker in the crippled children's agency was to mobilize and coordinate these services so that there was continuity in the medical and social plan and consistent guidance toward the ultimate goal of successful rehabilitation and placement in a job.

Sometimes a medical-social worker in a crippled children's program is asked to define the social problems that she believes should be referred to her. It is difficult to make such a definition, for a problem that calls for the medical-social worker's services is not basically the problem of the crippling condition. It is the reaction of the individual to his condition, and this reaction depends on the resources at his disposal—within himself, in his family, and in his community.

To be sure, a crippling condition probably always creates a problem. Many an individual, however—astonishingly many—finds strength within himself through which he meets his problem and can use the services and facilities in his community to become, within the limits of medical science, physically restored and in every way rehabilitated. Such a person, if given the information regarding the necessary resources—orthopedic nursing,

physical therapy, educational, rehabilitation—is in a position financially and emotionally to take advantage of them. Other persons, however, because of unfavorable conditions in the community, in the family, or in themselves, need special help in taking one or more of the steps along the road toward rehabilitation. If they do not get this help the medical care they receive will not be effective and the possibilities of rehabilitation will not be utilized. Betsey Barton in her recent book, "And Now to Live Again," has described the task that confronts persons to whom a severe crippling handicap has come. She speaks of the agonizingly slow mental adjustment that must be made to reach the victorious state of mind so necessary in coping with a new and terrifying world.

To sum up.—Successful rehabilitation of the physically handicapped individual includes: (1) the optimum of physical restoration. (2) personal and emotional adjustment to handicap. (3) vocational guidance and training for those who can benefit from them. But the social problems related to disability must be treated as well as the organic impairment if either medical care or rehabilitation is to be effective.

The program must meet the needs of the individual. Each patient comes from a different background and presents a condition and attitude peculiar to himself.

All the members of the medical team have a responsibility for recognizing and considering social factors affecting the individual. The role of the medical-social consultant in a State crippled children's program is threefold: To mobilize and help to coordinate services of the social and health agencies, to act as consultant in the area where medical and social factors come together, and in certain cases, to give direct service to the patient. The aim of all is rehabilitation. Any program that fails to plan for the social as well as medical rehabilitation of the crippled person and his eventual placement in the niche where he can best function falls short of its real objective.

A limited supply of reprints of this article will be available from the Children's Bureau, Washington 25, D. C.

SCHOOL DOORS BEGIN TO OPEN TO THE CHILDREN OF MIGRATORY FARM WORKERS

MANY A CHILD in a migratory farm family never learns to read and write. Some never learn to speak English. We may find this hard to realize, because we assume that all children in this country are required to go to school until they have completed a certain grade or reached a certain age set by the laws in their State. Indeed, we sometimes boast that all our children have an opportunity to get the full benefits of the American standard of education.

Our boasts sound empty against the hard fact that up to June 1, 1944, nearly 600,000 men 18 through 37 years of age had been rejected for military service because of educational or mental deficiency—a large proportion of whom were able to learn but had not had enough schooling to pass a fourth-grade test established by the military authorities.

Evidence of the lack of opportunity for migratory children has been found again and again over a period of years, in different parts of the country, in the course of studies made by such agencies as the National Child Labor Committee, the United States Office of Education, and the Children's Bureau and through information obtained from many different sources.

In one such study, made in Hidalgo County, Tex., in 1941, by the Children's Bureau and the United States Office of Education, the investigators found that of about 1,000 migratory children 6 through 17 years of age, who at the time of the study were living in their home communities, 500 were not enrolled in school, and 163 had never gone to school at all. About one-fourth of those who had never gone to school were 12 years of age or older and probably never would go to school.

Every year thousands of farm laborers and their families migrate from Texas to Michigan to work on the sugar beet crop and to harvest fruits and vegetables. Many migrate

A few communities show the way education can be put within their reach

by **IONE L. CLINTON**, Industrial Division, U. S. Children's Bureau

from other places too. How little schooling the children of these workers get is suggested by figures from 14 counties, published in the University of Michigan's School of Education Bulletin, October 1943. The author, Edgar G. Johnston, who called his study "Michigan's Stepchildren," found that although the school census for the 14 counties included 2,570 migratory children only a little more than one-fourth were enrolled in school at the time the information was collected.

Such reports confirm the statements of many persons who see these children working when they should be in school and who are acquainted with the children and

know how illiterate or near-illiterate many of them are.

Why do so many of these children never go to school at all? And why is it that those who do start school are unlikely to complete more than a few grades?

Let us look at some of the reasons.

What children are up against

When other children are in school large numbers of migratory farm children of school age are planting, weeding, or harvesting crops to eke out the meager income of their parents. Or else they are at home taking care of the babies and toddlers

A SCHOOL BUS has just carried these children from their school in a nearby city to their temporary homes in a farm-labor supply center in Texas. Their older brothers and sisters and their parents are in Texas to pick vegetables.

Photograph by Rothstein, Farm Security Administration



in the family while the older members of the family are in the fields.

It is just about impossible for a migratory family to remain in one locality long enough to permit the children to go to school for a full school term, for the families are needed to work in one locality after another—often at great distances—as one crop after another reaches its peak. In the winter months, which most of us think of as school time, the migratory farm family is likely to be working in States with a warm climate, harvesting oranges and grapefruit and many kinds of vegetables. In the spring they may be picking strawberries; in the fall, cotton in some States, apples in others.

Some migratory children go to school when they are in their home communities. Their home communities, however, are very likely to be in parts of the country where crops are harvested in the winter months. And even after a youngster reaches home and starts school—it may be from 1 to 3 months late in the term—he leaves school from time to time and works in the fields. And by March or April the family starts out again and the child leaves school.

In one locality the district school superintendent reports that last year a school in his district opened in the first week of September with only 30 per cent of the children in

the community present. By December nearly all of the children had come to school, but by the middle of April attendance had dropped to only 40 per cent. The rest of the children had either left the community or were working in the onion fields nearby. Another school in the district had already closed by that time because all the children had left the community with their families to follow the crops.

A few migratory farm families try to give their children some schooling in the various communities along their migratory route. But during the harvest season many rural schools close to release the local children for work in the fields. This of course interferes with the schooling of the local child but is much more of a handicap to the migrant child, who may find the schools closed in most of the places where he stops.

If the schools are open and the migratory child enrolls he may not be in school a month until, just as he did in the home community, he must leave school and move on with his family. This may happen again and again and may keep the child from ever completing a grade or even a school project he has undertaken.

It is discouraging to the children to be taken out of school before they have completed a school term and it is equally discouraging when they have to enter a new school—

almost certainly one with different content and rate of progress—in the middle of a school term.

As a result of the need to migrate the child drops behind his own age group and does not progress from grade to grade as does the child who attends the same school regularly.

What schools are up against

Because the children change schools often and because they attend so irregularly, teaching them becomes a special problem.

There are other reasons why it is difficult for schools to absorb these children, some of which are the result of their way of life.

Often the children are poorly dressed. They may be in ill health because of lack of sanitation, bad food, and the absence of medical care. Often because of poor living conditions and despite the efforts of their parents, the children are not clean. In addition a considerable number of migratory farm families speak a foreign language only and understand little English. Another considerable group of migrants are Negroes.

For these reasons and others, schools may refuse to accept migrant children. They may do this because they have no room for the migrant children, because they are unable

SUNSET SCHOOL is located in a Federal farm-labor supply center at Arvin, Calif. It was planned only for migratory farm children staying at the center, but now it is attended also by children who live permanently in the community.

Photograph by Leo B. Hart, Superintendent of Schools, Kern County, Calif.



to cope with their special needs, or because they do not feel obliged to take them in.

Bringing children and schools together

A number of efforts have recently been made to overcome the obstacles—work during school hours, irregularity of school attendance, and lack of community acceptance—that stand in the way of real educational opportunity for them.

Special funds provided.—An occasional State has enacted legislation for special State aid for schooling for migratory children. In 1943 New Jersey passed a law to apportion to each school district \$45 for each child of a farm worker not a resident of the State who attends. At present this provision has a time limit but consideration is being given to making it permanent. California for some years has had permanent legislation that provides special funds to aid counties in providing for emergency schools for these children.

Larger earnings by parents help.—Temporarily at least, the better wages and steadier work of the war years have reduced the pressure of family poverty that forces children to work in the fields and to lose schooling.

A Texas welfare officer reports

that some fathers in his county were earning enough last year to leave their families in their home communities so that the children could go to school during December and January while the fathers picked carrots in a nearby county.

A Government agricultural station through which many farm families pass on their migratory route reports that a few families with children returned earlier than usual from cotton picking in the fall of 1944. The parents said that they were doing so in order to give their children a better chance to enter school and that they were able to do so because their earnings were larger than usual. But even these parents, in order to earn their scant living, had to take their families away from home for considerable periods of the year and the schooling of their children still suffered.

Local communities are experimenting.—Some communities in which migratory farm families live during the time they are harvesting crops are making efforts to find out the best ways to give the children in these families an opportunity to go to school. They have found that a very important factor in getting them into school is to make the children feel themselves a part of the community.

How the community can help the agricultural migrant to feel a part of

the community and can interest the children in these families in attending school is shown by an experiment in Kern County, Calif. An elementary school was set up some years ago, with special funds provided by the State, for the children of workers in a Federal farm-labor supply camp at Arvin, Calif.

Through the years this school has grown in size and strength, has found a permanent place in the community, and has brought the people of the community and of the camp together. Neighboring farmers contribute pigs, rabbits, cows, sheep, and chickens to the school for the school lunch; the children learn to take care of the animals. Last year a swimming pool was built on the school grounds by the older boys, with the principal directing them and working with them. This pool is now also used by the community.

The county school superintendent reports that this year the upper-grade children of both groups of families—the families in the camp and those with permanent houses in the community—will attend the camp school together, and the lower-grade children of both groups will attend the district school.

Another effort to draw the migratory families into the life of the community and to study the special needs of the children and find out how to meet them was made by the Central Michigan College of Edu-

THIS SWIMMING POOL was built by the older boys of Sunset School, with the help and direction of the principal. The pool is used by the townspeople of Arvin, as well as by the migratory workers staying at the farm-labor supply center.

Photograph by Leo B. Hart, Superintendent of Schools, Kern County, Calif.



cation, Mt. Pleasant, Mich., during the summer of this year. The college established an experimental elementary school lasting 6 weeks. Interest in setting up the school was stimulated by the work of the Home Missions Council among migrants. These migrants, many of Mexican heritage, had been coming to the community for years to work in the beets from May to November. The Office of Inter-American Affairs financed the school. The college transported the children in the college bus, and the city schools cooperated by permitting the use of a school building for the session.

The group of 31 children from 6 to 12 years of age who attended this experimental session was made up of 16 migrant children and 15 children who lived in the community. Many of these migrant children spoke Spanish only and understood very little English. Because of this additional handicap they were even

shyer of strangers than the usual migratory child, and more effort was needed to make them feel a part of the school. Opportunity for speaking both Spanish and English was given all the children—thus the English-speaking children became aware of the language skill of the Spanish-speaking children. One of the members of the teaching staff was a young woman who herself had come to Michigan as a child with her parents and brothers and sisters to do seasonal work; the children went to school and the family stayed on in Michigan. This young woman recently graduated from Central Michigan College of Education.

School services are being extended to migratory workers.—

In Saginaw County, Mich., the county school commissioner for some years has been enlarging the teaching staff to take care of the migra-

tory children while they are in the community. Each year, the commissioner has engaged one extra teacher; and two more such teachers will be engaged this year for the 3 months that the migratory workers will be in the county. The fathers and mothers of the migratory children are made welcome at the local parent-teacher association meetings.

Another example of extending school services to seasonal farm workers' children can be found in the visiting teacher service of a school district in Texas, which thousands of seasonal farm workers consider their home community. This community now employs a Spanish-speaking visiting teacher to call at the home of children who have dropped out of school and to urge them to return. She investigates and reports on the economic status of the family; the health of the child; the sleeping accommodations, food, and clothing available to the child; and all other matters that may affect his school attendance. She gives the family advice as to how to overcome the handicaps to the child's attending school and if, after her first visit to the home the child does not come back to school, she returns again to see what more she can do.

If migratory farm children are to have an opportunity to get schooling equal to that recognized as the right of all American children, the conditions that deny migratory children this opportunity must be overcome. The protection of child-labor laws, as well as effective compulsory school-attendance requirements, are fundamental to broad attack on the problems of educating migrant children.

Moreover, additional facilities and services are needed so that schools can take in the additional children without curtailing school services to nonmigratory children.

In the meantime much more experimentation—and by many more communities—is needed to find out the best way to enable the migrant child to feel welcome in the school.

And most of all, a sound program of national planning and of cooperation among States is needed to give such children an opportunity for a good education.

EVERY RURAL CHILD HAS THE RIGHT

- 1 To a satisfactory, modern elementary education
- 2 To a satisfactory, modern secondary education
- 3 To an educational program that bridges the gap between home and school, and between school and adult life
- 4 Through his school to health services, educational and vocational guidance, library facilities, recreational activities, and, where needed, school lunches and pupil transportation facilities at public expense
- 5 To teachers, supervisors, and administrators who know rural life and who are educated to deal effectively with the problems peculiar to rural schools
- 6 To educational service and guidance during the entire year and full-time attendance in a school that is open for not less than 9 months in each year for at least 12 years
- 7 To attend school in a satisfactory, modern building
- 8 Through the school to participate in community life and culture
- 9 To a local school system sufficiently strong to provide all the services required for a modern education
- 10 To have the tax resources of his community, State, and Nation used to guarantee him an American standard of educational opportunity

—A Charter of Education for Rural Children.

First White House Conference on Rural Education.

October 3-5, 1944.

A limited supply of reprints of this article will be available from the Children's Bureau, Washington 25, D. C.

UNIVERSITY HOSPITAL PREPARES TO GIVE BETTER CARE TO NEWBORN BABIES

New nurseries aim to prevent epidemics and foster mother-baby relationships

HOSPITAL NURSERIES for newborn babies, planned to protect the baby from infection, to facilitate nursing care, and to help the mother get acquainted with her baby early are described in *The Modern Hospital* for July by Dr. P. A. McLendon, professor of pediatrics at George Washington University School of Medicine, Washington, D. C., and Dr. John Parks, professor of obstetrics and gynecology at the same school.

This plan is being carried out in the new George Washington University Hospital, Washington, D. C. Every baby's crib is to be placed in a separate cubicle, with glass partitions between cribs. The largest number of cribs in a single nursery will be eight, and no more than eight babies will be taken care of by a nurse at one time. The mothers' rooms are to be located near the nurseries, so that every mother can have her baby with her much of the time. Separate nursing units will be provided for premature babies and for babies showing any evidence of infection.

It has taken epidemics of impetigo, respiratory infections, and more particularly "neonatal diarrhea," to bring about a demand for changes in the architecture of hospital nurseries, say the authors, adding that hospitals in all parts of the United States have experienced the disaster of one or more of these tragic nursery epidemics.

In this connection the article notes that in the 8-year period 1935-42 the number of women who gave birth to their babies in hospitals increased by more than four-fifths. During that time the maternal mortality rate decreased more than half, but the mortality rate among infants in their first month of life decreased only a fifth.

The mortality rate for infants dying in the first month of life can and should be reduced a great deal, say Drs. McLendon and Parks, and improved nurseries can contribute to a real reduction in the neonatal deaths that result from preventable diseases.

Many hospitals, recognizing the danger to the babies that results from large nurseries, have built partitions to break up their nurseries into smaller units, the article says. Many of the made-over nurseries, however, lack proper plumbing facilities, adequate examination and treatment rooms, and necessary bedside working space. These deficiencies have made physicians conscious of the need for radical changes in the design for hospital nurseries.

Foremost of these changes, say the authors, must be provisions for protection against infection. In addition, the structure of nurseries should be changed so they not only serve as protected quarters but contribute as maternal centers of education in infant care and development.

A nursing assignment under the plan will consist of one eight-crib nursery, or two four-crib nurseries, or eight one-crib nurseries. Irrespective of the size or location of these units, the article says, no infection need spread from one to the other of these independently arranged nurseries without gross neglect in supervision.

The mothers' rooms are planned in relation to the nurseries so that the baby can be rolled to his mother's room in a mobile bassinet, with a minimum of corridor travel, as this exposes him to infection.

Under this plan the mother will have the privilege of seeing "the early developmental changes that characterize the newborn and that can be appreciated only through

more prolonged periods of observation than has been the practice in the hospital care of infants."

The mother will also have an early opportunity to learn from her nurse what Drs. McLendon and Parks call the "simple but disturbing first lessons" in breast or bottle feeding, in eructating the baby, changing his diaper, bathing him, and otherwise caring for him.

It is understood that the baby will not be left in the mother's room during visiting hours and that visitors will not be allowed to enter the room during nursing periods.

Every nursery for normal infants will provide 25 square feet of floor space for each baby.

Floors, walls, and partitions are to be constructed so that there will be a minimum of ledges that catch dust and of areas inaccessible for cleaning.

All partitions will be of clear glass so that a full view of the entire area may be had from any point. Each nursery will have an individual wall light in each cubicle, and also ceiling lights hooked up to a constant dim light and a switch for indirect floor lighting. Each cubicle will have its own "plug-in" for use in attaching any necessary electrical devices.

Attached to every nursery will be an examination-treatment room, as well as a separate chart and gowning room. In the latter room the physician may examine the baby's record and look at the baby through the glass partition.

Lavatories will be located in every nursery, examination-treatment room, and chartroom.

View windows, with opaque sliding panels, will permit visitors to see the babies.

Two four-crib nurseries will be placed opposite each other on a corridor, so that a nurse can supervise the care of eight babies. Each four-crib nursery will be placed between two double rooms for mothers, and viewing windows will be placed between the mother's room and the nursery.

As one step further in the idea of smaller nursery units and closer mother-baby relationships, one wing of the hospital will have individual nurseries, each connected with the mother's bedroom. Each of these individual nurseries has a viewing window between the nursery and the corridor, so that one nurse can observe all eight babies without disturbing the mothers. A few of the mothers' rooms will have bath facilities also.

Turning to the cost of hospital care, the mother's room and the infant's nursery space should be considered separately, say Drs. McLendon and Parks. Charges for infant care in voluntary hospitals rarely pay for nursery costs, they add, and under any acceptable standard good nursery care is expensive. In hospital economy, according to the authors, the infant should be treated as the important end-product rather than a by-product of the maternity division.

In their conclusions, Drs. Parks and McLendon stress the point that small functional units are the surest means of controlling nursery infections. With regard to the effect of locating the mothers' rooms near the nurseries, the authors remark that encouragement in the early mother-baby relationship should be a tremendous factor in breast feeding. The pendulum of ultramodern scientific management of early infancy is slowly but surely swinging back toward a more rational and normal attitude, they continue. In an atmosphere of hospital helpfulness, they say, this new nursery design will develop in the mother more confidence in herself and a better understanding of her infant than have been possible in previous hospital practices.

The article in *The Modern Hospital* includes floor plans for nurseries for normal babies—an eight-crib unit, a four-crib unit, and a single nursery attached to the mother's bedroom; also floor plans for a premature nursery suite.

By permission of *The Modern Hospital* the Children's Bureau has reprinted the article that is summarized here, and single copies of the complete article, including the floor plans, may be had without charge by writing to the Bureau.

C. B. NEWS NOTES

Chief of Children's Bureau Appoints Advisory Committee of Trade Union Women

On August 22, 1945, the Chief of the Children's Bureau announced the appointment of an Advisory Committee of Trade Union Women, consisting of eight women representatives of labor unions affiliated with the American Federation of Labor and the Congress of Industrial Organizations. This committee will consult with the Bureau on the formulation of programs affecting women workers and their children and employed young people and on methods of informing the unions of these programs.

The subjects under special consideration at the first meeting of the committee, which was held on September 25, included needs for continuing facilities for day-care of children of women workers; union plans for participating in efforts to expand community services for children and youth; and measures needed this year to keep boys and girls in school, protect young workers, and help in the readjustment of young war workers who lose their jobs.

Adviser on Dental Services Appointed on Staff of Children's Bureau

The appointment of Dr. John T. Fulton to the staff of the Children's Bureau as adviser on dental services was announced on September 12. This is the first time that the Bureau has had a specialist in this field on its staff, although Federal funds for maternal and child-health services have been available to State health agencies for the provision of dental-health services for mothers and children since the Social Security Act was passed in 1935.

Dr. Fulton, who is attached to the Division of Research in Child Development, will conduct research on the needs of children for dental care, methods of providing care, and standards of training for dental per-

sonnel. He will also work with the Division of Health Services, giving consultation service to State health agencies on the extension and improvement of dental-health services for children and pregnant women.

Dr. Fulton comes to the Children's Bureau from the Connecticut State Department of Health, where he had been Chief of the Division of Dental Hygiene since 1942.

Children's Bureau Advisory Committee on Statistics Concerning Children

The Children's Bureau Advisory Committee on Social Statistics has been reconstituted as the Advisory Committee on Statistics Concerning Children, in order to relate it more closely to the Bureau's entire program of statistical research. As originally constituted the committee served as an advisory body to the Children's Bureau on the collection of health and welfare statistics in urban areas through the social-statistics project, for which the Children's Bureau terminated its responsibility as of June 30, 1945.

The reconstituted committee functions through two subcommittees—one on child-welfare statistics, the other on juvenile-delinquency statistics. The expansion of the committee through the addition of other subcommittees is contemplated in the future.

The subcommittee on juvenile-delinquency statistics began its work with a reconsideration of the reporting of juvenile-court statistics. Proposals for reorienting and amplifying these reports on the basis of the committee's recommendations have been sent out to State agencies concerned with juvenile-court statistics by the Bureau for comments and suggestions.

The subcommittee on child-welfare statistics at its first meeting considered various problems connected with the improvement and extension of current reporting of statistics by State agencies administering child-welfare services.

TEN YEARS OF PROGRESS IN REDUCING MATERNAL AND INFANT MORTALITY

With figures showing changes in the rates between the 2 years 1942-43

by **MARJORIE GOOCH, Sc.D.,**
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WITH PUBLICATION by the Bureau of the Census of data on births and deaths for 1943, it is possible for the first time to compare infant and maternal mortality rates over a 10-year period. Although much information on these subjects has been available for a number of years, the first year in which reasonably satisfactory data were available for every State in the Union was 1933.

Between 1933 and 1943 the maternal mortality rate declined 60 percent—from 61.9 deaths directly due to pregnancy and childbirth in 1933 per 10,000 live births to 24.5 such deaths in 1943. The infant mortality rate during the same years dropped from 58.1 deaths of infants under 1 year of age per 1,000 live births to 40.4 in 1943—a decrease of 31 percent.

The reporting of these comparable figures for the entire United States is a milestone in the history of vital statistics.

Development of birth and death registration in this country has been a long, slow process.

The first vital statistics published by the Federal Government were for the year 1850; these were based on data collected during the decennial population census of that year. Although the information covered the entire United States, the method of obtaining the data made it inevitable that they would be incomplete and inaccurate.

In some of the earlier-settled States, official registration of certain facts about births and deaths at the time the birth or death occurred had been in force since early colonial times. This principle—registration

rather than enumeration—was used in the establishment in 1900 of the death-registration area. Only 10 States, the District of Columbia, and a small number of cities were included in this first registration area. But even this small beginning required that some central agency be given responsibility for the annual collection, compilation, and publication of the information. The Bureau of the Census was given this responsibility, and from this small beginning the structure of the present-day vital statistics has grown up. Similarly a birth-registration area was begun in 1915, with only 10 States and the District of Columbia included. Gradually States were added to each of these registration areas until in 1933 all the States were included in both the birth- and the death-registration areas.

Admission of a State to either registration area required proof that certain standards of completeness of registration had been met.

The registration procedure—that is, the filing of an official document giving specified information about the birth or death soon after it occurred—involves many persons and procedures. The certificate is filed with a local registrar, forwarded by him after he has made a record of certain facts, to the State registrar. In the office of the State registrar copies are made of the statistical information and sent on to the Federal Bureau of the Census which makes the Nation-wide tabulations and analyses of the data.

It is obvious that with the millions of records involved each year, definite classifications of many items must be agreed upon. Sometimes it becomes necessary or advisable to change some of the definitions and when this is done direct comparisons of current data with those published

earlier are sometimes difficult or even impossible to make.

The classifications of causes of death are made according to the International List of the Causes of Death. This list is revised every 10 years to keep pace with advancement in medical knowledge. The latest revision was made in 1938, and deaths that occurred from 1939 through 1943 were classified according to this latest edition. Deaths that occurred from 1933 through 1938 were classified according to the 1929 edition. There were more extensive changes in the classification of causes of maternal deaths than of infant deaths, but the major discrepancies brought about by the revision have been overcome by the use of broad groups of causes. There are hidden variations, however, that cannot be corrected by this practice.¹

Another change which was made in the tabulations of the Bureau of the Census during the 10-year period from 1933 to 1943 was the change from a place-of-occurrence to a place-of-residence basis. From 1933 through 1936 all births and deaths were tabulated according to the place where the birth or death took place. Data tabulated according to place of residence, however, have much more public-health significance. For this reason, from 1937 on most tabulations have been made on this basis. This change does not affect the statistics for the United States as a whole, except those relating to urban and rural areas. For most States, figures for births and maternal and infant deaths are not greatly different whether on an occurrence or on a residence basis. The Bureau of the Census has continued to publish some data on an occurrence basis as well as on a residence basis. For data that are not available on an occurrence basis direct comparisons

between 1933 and 1943 for geographic subdivisions are not valid.

As a whole, however, in spite of limitations, the figures for both maternal and infant mortality are comparable.

Before examining the mortality rates, let us look at the figures for births during the decade 1933-43.

BIRTHS

Birth rates

In the 10 years from 1933 to 1943 there was an increase in the birth rate of 30 percent. For 1933, 2,081,232 live births were registered in the United States; this meant a birth rate of 16.6 per 1,000 estimated population. For 1943, 2,934,860 live births were registered—a birth rate of 21.5 per 1,000 estimated population including the armed forces overseas.

The birth rates for the United States from 1933 to 1943 are as follows:

Year	Rate
1933.....	16.6
1934.....	17.2
1935.....	16.9
1936.....	16.7
1937.....	17.1
1938.....	17.6
1939.....	17.3
1940.....	17.9
1941.....	18.9
1942.....	20.9
1943.....	21.5

Race

The proportion of Negro births decreased slightly from 1933 to 1943. In the earlier year 11.8 percent of all live births were Negro; in 1943, 11.1 percent. In both years Mississippi had the highest proportion of Negro births (54 percent in 1933 and 53 percent in 1943). Idaho and North Dakota had less than 0.1 percent in each year. The greatest concentration of Negro births occurs in fewer than one-fourth of the States and during the 10-year period there was little change in the picture. Between 1933 and 1943 the States with the highest proportion of Negro births showed a slight decrease in this proportion. In other words, there has been a shift in the Negro population away from the southern States.

Attendant at birth

Data for 1933 on the number of

births occurring in hospitals and attended by physicians are not available from the Bureau of the Census, but from data published in the Journal of the American Medical Association for March 31, 1934, it seems probable that in 1933 less than 35 percent of the births took place in hospitals. By 1943 this percentage had risen to 72 percent.

The percentage of hospital births from the first year for which such data are available from the Bureau of the Census to 1943, and the percent increase from each year to the next, are as follows:

PROPORTION OF BIRTHS IN HOSPITALS

Year	Percentage of all live births	Percent increase
1935.....	37	
1936.....	41.....	10.8
1937.....	45.....	9.8
1938.....	48.....	6.7
1939.....	51.....	6.3
1940.....	56.....	9.8
1941.....	61.....	8.9
1942.....	68.....	11.5
1943.....	72.....	5.9

The proportion of hospital births increased 95 percent during this period. More complete data for 1935 and 1943 are given in table 1.

The increase in proportion of hospital births has been more pronounced for whites than for Negroes when the entire 8-year period is considered. Between 1942 and 1943, however, the proportion of Negro births in hospitals increased 10 percent while that for white births increased only 6 percent.

In 1943 the proportion of births occurring in hospitals (table 2) ranged from 97.3 percent for Connecticut to 26.6 percent for Mississippi. Thirty-two States had a higher proportion of hospital births than that shown for the United States as a whole.

Urban and rural

Since hospital facilities are largely located in urban areas, the natural corollary to the increased proportion of births in hospitals would be an increase in births occurring in urban areas. Table 3 shows that in 1943 73 percent of all births occurred in urban areas, but only 58 percent of the mothers lived in urban areas. In other words, 15 percent of the women having babies in 1943 lived in rural areas but went to cities for

care during delivery.

MATERNAL MORTALITY

In 1933 there were 12,885 women who died from causes directly due to pregnancy and childbirth. In 1943 this number had dropped to 7,197; the risk of dying from these causes was actually reduced more than is indicated by the difference between these figures, because there were over 800,000 more births in 1943 than in 1933.

The number of puerperal deaths per 10,000 live births declined from 62 in 1933 to 25 in 1943—a reduction of 60 percent, which is highly significant statistically. The differences between the maternal mortality rates by race are as follows:

	MATERNAL DEATHS PER 10,000 LIVE BIRTHS			
	Total	White	Negro	Other
1933.....	61.9	56.4	100.0	76.2
1943.....	24.5	21.1	51.3	44.6
Percent change	-60.4	-62.6	-48.7	-41.5

Although for this total 10-year period there was a greater reduction in maternal mortality for whites than for Negroes, nevertheless, from 1941 to 1943 the rate for Negroes decreased more sharply than that for whites, as is shown in the following comparison.

	PERCENT CHANGE IN MATERNAL DEATH RATES	
	1941-42	1942-43
Total	-18	-5
White	-17	-5
Negro	-20	-7
Other	+3	+3

The reduction in maternal mortality is even more striking than the total figures show because during the later years of the decade 1933 to 1943 there was an increased proportion of first births and of births to young mothers, both of which factors are known to be associated with high maternal mortality.²

Age at death

The proportionate reduction in maternal mortality for each age group is shown in table 4. The smallest reduction occurred among mothers under 15 years of age and the largest reduction among those 20-24 years. The latter age group showed the lowest maternal mortality rate both in 1933 and in 1943.

The higher mortality in the very young group may be the result of less prenatal supervision and a high percentage of first births, as well as relatively incomplete physio-

logical development. It is possible that in 1943 somewhat more adequate prenatal care was available to this group than in 1933 and that as a result the rate was reduced.

But apparently, other factors associated with high maternal mortality rates, such as physiological immaturity and parity, made the reduction in the rate less pronounced for

TABLE 1.—NUMBER AND PERCENT OF BIRTHS, BY RACE, ACCORDING TO PERSON IN ATTENDANCE, LIVE BIRTHS; UNITED STATES, 1935 AND 1943

Race	Live births	Number attended by—			Percent attended by—		
		Physician		Non-medical attendant	Physician		Non-medical attendant
		In hospital	In home		In hospital	In home	
1943							
All races.....	2,934,860	2,115,582	615,754	203,524	72.1	21.0	6.9
White.....	2,594,763	2,002,313	534,177	58,273	77.2	20.6	2.2
Negro.....	324,865	102,152	79,405	143,308	31.5	24.4	44.1
Other.....	15,232	11,117	2,172	1,943	73.0	14.3	12.7
1935							
All races.....	2,155,105	795,629	1,089,832	269,644	36.9	50.6	12.5
White.....	1,888,012	746,974	1,019,271	121,767	39.6	54.0	6.4
Negro.....	255,124	44,059	66,218	144,847	17.3	25.9	56.8
Other.....	11,969	4,596	4,343	3,030	38.4	36.3	25.3

TABLE 2.—PERCENT OF BIRTHS, BY PERSON IN ATTENDANCE, LIVE BIRTHS; UNITED STATES AND EACH STATE, 1943

Area	Percent attended by —			Area	Percent attended by—		
	Physician		Non-medical person		Physician		Non-medical person
	In hospital	In home			In hospital	In home	
United States.....	72.1	21.0	6.9	Montana.....	91.4	7.1	1.5
Alabama.....	34.5	40.1	25.4	Nebraska.....	78.8	21.1	.1
Arizona.....	77.5	13.9	8.6	Nevada.....	92.5	6.6	.9
Arkansas.....	35.1	45.0	19.9	New Hampshire.....	89.9	10.1	(1)
California.....	93.8	5.6	.6	New Jersey.....	91.0	7.4	1.6
Colorado.....	77.5	20.7	1.8	New Mexico.....	50.2	27.8	22.0
Connecticut.....	97.3	2.6	.1	New York.....	93.7	5.7	.6
Delaware.....	81.1	11.8	7.1	North Carolina.....	45.7	36.4	17.9
District of Columbia.....	92.9	7.1	(1)	North Dakota.....	81.2	17.3	1.5
Florida.....	61.8	18.5	19.7	Ohio.....	80.4	19.5	.1
Georgia.....	45.5	27.6	26.9	Oklahoma.....	61.3	34.9	3.8
Idaho.....	87.6	12.3	.1	Oregon.....	95.6	4.1	.3
Illinois.....	87.6	12.2	.2	Pennsylvania.....	77.9	21.9	.2
Indiana.....	75.6	24.3	.1	Rhode Island.....	89.2	10.3	.5
Iowa.....	79.0	20.9	.1	South Carolina.....	35.7	28.0	36.3
Kansas.....	78.2	21.7	.1	South Dakota.....	77.0	21.2	1.8
Kentucky.....	33.3	55.2	11.5	Tennessee.....	42.2	50.2	7.6
Louisiana.....	54.5	21.3	24.2	Texas.....	61.7	24.5	13.8
Maine.....	75.9	23.6	.5	Utah.....	87.5	12.1	.4
Maryland.....	70.7	23.9	5.4	Vermont.....	75.0	24.9	.1
Massachusetts.....	93.8	6.2	(1)	Virginia.....	50.7	32.5	16.8
Michigan.....	84.3	15.5	.2	Washington.....	96.4	3.4	.2
Minnesota.....	85.6	13.9	.5	West Virginia.....	38.1	58.4	3.5
Mississippi.....	26.6	30.6	42.8	Wisconsin.....	83.3	16.5	.2
Missouri.....	64.3	32.9	2.8	Wyoming.....	87.9	11.7	.4

¹ Less than 0.1 percent.

TABLE 3.—LIVE BIRTHS, URBAN¹ AND RURAL, UNITED STATES, 1933 AND 1943

Area	1933		1943			
	Occurrence		Occurrence		Residence	
	Number	Percent	Number	Percent	Number	Percent
Total.....	2,081,232	100	2,934,860	100	2,934,860	100
Urban.....	1,142,596	55	2,137,941	73	1,714,164	58
Rural.....	938,636	45	796,919	27	1,220,696	42

¹ Urban places are those having 2,500 or more population at the last population census.

this age group.

At the other end of the age scale, the high rates for older mothers are undoubtedly the results of complicating diseases and the effects of multiparity.

Causes of maternal deaths

It is gratifying to know that for the first 10 years of Nation-wide birth and death registration such a dramatic reduction in the maternal mortality rate took place and that the age usually considered most favorable for maternity was even less hazardous in 1943 than it was in 1933. Is this reduction due to uniform reduction in all causes of maternal death or have deaths from certain causes been reduced more than those from other causes? Unfortunately the comparison of causes of maternal deaths is extremely difficult because of the extensive changes made in the International List for the puerperal causes.

1933-43—Comparison of deaths due to infection and to toxemia can be made with considerable accuracy for the years 1933 and 1943 but comparison of deaths due to hemorrhage is not valid.

When the maternal deaths for 1933 and 1943 are reclassified to make them as nearly comparable as possible, it is found that the proportion of deaths due to infection and to toxemia did not change markedly. The reduction in the maternal mortality rate due to infection was, however, greater than the reduction in that due to toxemia, as may be seen from the following comparison:

	MATERNAL DEATHS PER 10,000 LIVE BIRTHS			
	All causes	Infection	Toxemia	All other
1933.....	61.9	23.5	14.7	23.7
1943.....	24.5	8.8	6.2	9.5
Percent change .	-60.4	-62.6	-57.8	-59.9

The actual decrease in the rate from infection may be even greater than the figures indicate since

deaths from criminal abortion with infection are not included in the rate for 1933 but are included for 1943.

The decline in deaths from infection is probably associated with the advent of chemotherapy, the increased use of blood transfusions, the trend away from operative delivery, and better hospital regulations for asepsis.

The decrease in death rate from toxemia is undoubtedly the result of better prenatal care, with especial emphasis on better diet, and of the trend away from operative delivery of patients with eclampsia.

1942-43 — The more detailed classification of maternal deaths for 1942 and 1943, made possible by the 1939 revision of the International List, is shown in table 5. Using this classification it is possible to classify more of the deaths in the three major groups—infection; toxemia; hemorrhage, trauma, or shock. Table 5 shows that in 1943

TABLE 4.—MATERNAL MORTALITY BY AGE; UNITED STATES, 1933 AND 1943

Age at death	1943			1933			Percent change 1933-43
	Maternal deaths per 10,000 live births	Maternal deaths	Live births	Maternal deaths per 10,000 live births	Maternal deaths	Live births	
Total.....	24.5	7,197	2,934,860	61.9	12,885	2,081,232	-60.4
10-14 years.....	99.0	37	3,737	137.9	37	2,684	-28.2
15-19 years.....	21.7	747	343,550	57.4	1,441	251,131	-62.2
20-24 years.....	15.8	1,473	930,015	42.6	2,646	620,418	-62.9
25-29 years.....	19.3	1,589	822,249	51.0	2,753	539,606	-62.2
30-34 years.....	29.9	1,528	510,413	72.9	2,578	353,495	-59.0
35-39 years.....	51.0	1,268	248,870	106.4	2,324	218,411	-52.1
40-44 years.....	74.2	493	66,406	124.8	952	76,261	-40.5
45 years and over.....	107.6	54	5,020	179.5	135	7,522	-40.1
Age unknown.....	17.4	8	4,600	16.2	19	11,704	+ 7.4

TABLE 5.—MATERNAL DEATHS FROM EACH CAUSE, BY TIME OF DEATH; UNITED STATES, 1943 AND 1942

Cause of death	Number of maternal deaths									
	Total		During or after ectopic pregnancy		During or after abortion ¹		Before delivery ²		During or after childbirth ³	
	1943	1942	1943	1942	1943	1942	1943	1942	1943	1942
All causes.....	7,197	7,267	332	346	1,165	1,231	1,022	1,110	4,678	4,580
Infection.....	2,593	2,808	62	76	789	929	179	190	1,563	1,613
Toxemia.....	1,936	1,866	—	—	110	79	690	777	1,136	1,010
Eclampsia.....	983	969	—	—	—	—	347	384	636	585
Albuminuria and nephritis.....	446	437	—	—	—	—	158	184	288	253
Other toxemias.....	507	460	—	—	110	79	185	209	212	172
Hemorrhage, trauma, or shock.....	1,991	2,018	270	270	113	111	65	61	1,543	1,576
Other and unspecified causes.....	677	575	—	—	153	112	88	82	436	381

¹ Abortion: Termination of a uterine pregnancy prior to 7 lunar months (28 weeks) of gestation.

² Deaths before delivery: Deaths of all women who died undelivered during uterine pregnancy.

³ Childbirth: Termination of a uterine pregnancy at 7 lunar months (28 weeks) or more of gestation.

2,593 (36 percent) of the 7,197 maternal deaths were due to infection; 1,991 (28 percent) to the group of causes, hemorrhage, trauma, or shock; 1,936 (27 percent) to toxemia; and 677 (9 percent) to other and unspecified causes. The proportion in each cause group for 1943 was very similar to that for 1942.

Death rates from infection decreased proportionately more between 1942 and 1943 than those from any other cause group, as is shown in the following comparison:

MATERNAL DEATHS PER 10,000 LIVE BIRTHS					
	All causes	Infection	Toxemia	Hemorrhage, trauma, and shock	Other or unspecified causes
1942....	25.9	10.0	6.6	7.2	2.0
1943....	24.5	8.8	6.6	6.8	2.3
Percent change	-5	-12	0	-6	+15

In 1943 the majority of the maternal deaths occurred during or after childbirth—4,678 deaths or 65 percent of the total. During or after abortion there were 1,165 deaths (16 percent); 1,022 deaths (14 percent) occurred before delivery; and 332 (5 percent) during or after ectopic pregnancy.

The following comparison shows that the greatest proportionate decrease in the maternal mortality rates between 1942 and 1943 in respect to time of death was for deaths occurring before delivery.

MATERNAL DEATHS PER 10,000 LIVE BIRTHS					
	During or after ectopic pregnancy	During or after abortion	Before delivery	During or after childbirth	
1942....	1.2	4.4	4.0	16.3	
1943....	1.1	4.0	3.5	15.9	
Percent change	-8	-9	-13	-2	

Maternal mortality by States

In 1933 Florida had the highest maternal mortality rate, 115 per 10,000 live births; and Idaho the lowest, 43. In 1943 the State with the highest rate (New Mexico, 47) was not much above the one with the lowest rate in 1933, and two States (Oregon and Minnesota) had rates below 15.

In 1933 half the States had rates higher than 58.8 per 10,000 live births and half had rates lower than that. In 1943 the median rate was 22.5 per 10,000 live births.

Every State showed marked re-

duction in its maternal mortality rate during the 10-year period. The smallest reduction was 41 percent for North Dakota and the largest was 76 percent for Nevada.

In the last 2 years of the decade, the maternal mortality rate for the United States dropped 5 percent, but in those same 2 years it rose for 14 States. (Table 6.) Most of these 14 States have small numbers of maternal deaths in a single year, and therefore the rates are greatly affected by chance variations. A few of the 14 States, however, have comparatively large numbers of maternal deaths (California and Ohio for example) so that the increased rate in those States may mean an actual increase in the risk of dying from causes associated with childbirth.

Possibility of future reduction in maternal mortality

Gratifying as is the reduction in maternal mortality, the fact that more than half the States in 1943 had maternal mortality rates lower than the average for the country as a whole indicates that further reduction is possible. Although the States differ so widely in such population factors as race and age, in economic conditions, and in availability of medical care that it probably will not be possible for all States to reduce their rates to the level that was lowest in 1943, nevertheless advancements in medical knowledge would lead one to expect further reductions for the United States as a whole.

At the Conference on Better Care for Mothers and Babies, held in 1938, data were presented indicating that the maternal death rate might be reduced one-half to two-thirds.³

These estimates were based on various special studies of maternal deaths which had been made at different times from 1930 to 1935.

Additional data published in the proceedings of this conference showed that the reduction in the death rate from toxemia was greater than that from the other major cause groups. But in a few years, the death rate from infection showed a greater reduction than any other group.

The fact that the maternal mortality rate was reduced 60 percent in the 10 years from 1933 to 1943, practically substantiates the 1938 prognostication of a two-thirds reduction.

The fact that the goal set several years ago has been so nearly reached does not mean that further reduction is impossible. The fact that the rate for Negro women in 1943 was more than twice that of white women should point to ways of further reducing the total maternal mortality. If in 1943 the maternal mortality rate for Negroes had been reduced by a half but the number of both white and Negro births and the mortality rate for whites had remained unchanged, the rate for both races would be reduced more than 10 percent.

INFANT MORTALITY

In 1933 a total of 120,887 infants died before their first birthday. In 1943 the number dropped to 118,484 in spite of the increased number of infants born in the later year.

The infant mortality rate dropped from 58 to 40 per 1,000 live births—a percent change of 31, as is shown in the following comparison:

INFANT DEATHS PER 1,000 LIVE BIRTHS				
	Total	White	Negro	Other
1933.....	58.1	52.8	85.4	127.5
1943.....	40.4	37.5	61.5	84.6
Percent change..	-30.5	-29.0	-28.0	-33.6

This reduction, although not so great as the reduction in maternal mortality rate, nevertheless represents a real improvement and is not due to chance variations.

For this 10-year period the percentage reduction in mortality rates has been about the same for white and Negro infants, but during the last 2 years of the decade the infant mortality, like the maternal mortality, has declined proportionately more for Negro infants than for white infants.⁴ The amount of change for each race is as follows:

PERCENT CHANGE IN INFANT MORTALITY RATES		
	1941-42	1942-43
Total	-11	0
White	-10	+1
Negro	-13	-4
Other	-17	+14

Age at death

More infants died during the first month of life in 1943 than in 1933 but because of the larger number of births in the later year, the neonatal mortality rate declined 27 percent during the 10-year period.

Until 1940 the rates for deaths during the first day of life had decreased very little, but in the last 2 years there has been a noticeable drop in this rate. This decrease in rate for the first day possibly is related to improved maternal health, since the largest proportion of the early infant deaths are due to prenatal and natal causes.

More of the infant deaths occurred in the first day of life in 1943 than in 1933 (29 percent in 1943 and 26 percent in 1933). Also, more of the infant deaths occurred during the first month of life in 1943 than in 1933 (61 percent in 1943 and 58 percent in 1933). The decreases in the rates for different ages at death are as follows:

	INFANT DEATHS PER 1,000 LIVE BIRTHS		
	First year	First month	First day
1933.....	58.1	34.0	15.1
1943.....	40.4	24.7	11.6
Percent change.	-30.5	-27.4	-23.2

Causes of infant death

Because of changes in the Inter-

national List of Causes of Death and in the basic tabulations of causes of infant death published by the Bureau of the Census, the groupings of causes previously used by the Children's Bureau cannot now be followed exactly. It is possible, however, to make comparisons for the most important causes of infant death.

In 1933, 53 percent of the infant deaths were due to prenatal and natal causes; in 1943, 60 percent. The mortality rates, however, decreased for all the major cause groups, as is shown in the following comparison:

	INFANT DEATHS PER 1,000 LIVE BIRTHS			
	Prenatal and natal causes	Influenza and pneumonia	Dysentery, diarrhea and enteritis	Epidemic and other communicable diseases
1933....	30.6	9.4	6.0	2.3
1943....	24.1	6.2	3.3	1.3
Percent change	-21.2	-34.0	-45.0	-43.5

Between 1933 and 1943 the greatest reduction was in the death rate for the dysentery, diarrhea and enteritis group (45 percent), although the rate for the group, epidemic and other communicable diseases, was reduced almost as much (44 percent). These diseases are the ones most easily affected by public-health measures, such as pure water and milk supplies, adequate sewage disposal, and immunization, and there-

fore would be expected to show marked decreases.

The reduction of 34 percent for influenza and pneumonia is undoubtedly the result of the use of sulfa drugs.

The numerically largest group, prenatal and natal causes, showed a reduction in the mortality rate of 21 percent although this was a smaller gain than was shown by the other groups of diseases.

In 1943 there were 5,000 more infant deaths than in 1942, but because of the larger number of births the rates for the 2 years were the same, 40.4 per 1,000 live births. The prenatal and natal causes showed a slight drop (3 percent) in mortality rate. The other specific causes were higher in 1943 than in 1942. (Table 7.)

Infant mortality by States

In 1933 New Mexico had the highest infant mortality rate (136.1) and Washington the lowest (38.8). In 1943 New Mexico still had the highest rate but it had dropped to 91.6, a reduction of almost one-third. The lowest rate in 1943 was for Connecticut—29.8. In 1933 half the States had rates above 55.4 and half below that figure; in 1943 the point which divided the States equally was 39.6 per 1,000 live births. Every State showed a reduction in

TABLE 6.—MATERNAL MORTALITY; UNITED STATES AND EACH STATE, 1943 AND 1942¹

Area	1943		1942		Area	1943		1942	
	Number of maternal deaths	Rate (deaths per 10,000 live births)	Number of maternal deaths	Rate (deaths per 10,000 live births)		Number of maternal deaths	Rate (deaths per 10,000 live births)	Number of maternal deaths	Rate (deaths per 10,000 live births)
United States....	7,197	24.5	7,267	25.9	Montana.....	20	17.5	26	22.2
Alabama.....	260	33.5	235	33.0	Nebraska.....	42	16.8	45	19.0
Arizona.....	38	26.6	49	38.7	Nevada.....	6	19.8	2	7.2
Arkansas.....	168	39.4	158	37.0	New Hampshire.....	25	26.7	11	12.0
California.....	357	20.5	306	19.8	New Jersey.....	161	19.4	162	19.8
Colorado.....	63	25.9	44	18.7	New Mexico.....	71	46.7	68	48.1
Connecticut.....	63	16.2	67	18.0	New York.....	521	21.0	545	22.3
Delaware.....	15	24.1	9	15.9	North Carolina.....	306	32.4	307	34.2
District of Columbia.....	35	21.8	41	27.0	North Dakota.....	39	29.1	29	21.7
Florida.....	173	37.0	166	40.6	Ohio.....	324	22.5	300	20.8
Georgia.....	307	39.2	300	41.4	Oklahoma.....	122	25.1	142	30.9
Idaho.....	29	23.4	30	26.2	Oregon.....	38	14.9	38	16.9
Illinois.....	320	20.5	326	20.9	Pennsylvania.....	493	24.7	530	26.9
Indiana.....	149	20.0	178	24.2	Rhode Island.....	33	22.5	26	18.3
Iowa.....	80	16.8	94	19.4	South Carolina.....	240	44.3	260	53.2
Kansas.....	77	21.4	88	25.9	South Dakota.....	20	15.6	25	20.1
Kentucky.....	163	24.9	175	26.9	Tennessee.....	204	29.1	197	30.2
Louisiana.....	190	32.1	201	34.6	Texas.....	420	25.5	440	30.4
Maine.....	42	22.2	38	21.4	Utah.....	27	15.7	27	17.1
Maryland.....	85	17.9	88	19.9	Vermont.....	16	21.9	15	20.9
Massachusetts.....	173	20.1	174	21.0	Virginia.....	210	29.1	220	32.4
Michigan.....	226	18.0	257	20.7	Washington.....	72	16.2	68	17.4
Minnesota.....	84	14.4	96	16.3	West Virginia.....	126	29.1	103	23.5
Mississippi.....	236	39.4	249	43.9	Wisconsin.....	127	19.7	114	17.8
Missouri.....	183	25.3	182	25.7	Wyoming.....	9	15.5	13	23.4

¹ Tabulations are by place of residence of deceased.

infant mortality rates during the 10-year period. The greatest reduction was for North Dakota (42 percent). The least reduction was shown by Washington (10 percent), which had the lowest rate in 1933.

The infant mortality rate, unadjusted for the changing number of births, was the same, 40.4 per 1,000 live births, for 1942 and 1943. For 21 States the rate was higher in 1943 than in 1942. New Hampshire showed the highest percentage in-

crease, 28 percent. The largest decrease was 18 percent, for Wyoming. (Table 8.)

Possibility of further reduction in infant mortality

Although it may not be possible to reduce the infant mortality rate for the country as a whole to the low rate of 30 per 1,000 live births attained by 2 States in 1943, certainly the fact that 23 States showed rates above the national rate would

indicate that some reduction is possible.

The goal of reducing neonatal deaths by a half, which was suggested in the 1930's, was not reached during this 10-year period.

The most important single cause of death is premature birth. Better prenatal care of mothers should reduce the number of infants prematurely born and better care of prematurely born infants should reduce the number of infants dying from this cause.

¹For a discussion of the problem of classification of causes of death, see *Vital Statistics Rates in the U. S., 1900-1940*, by Forest E. Linder and Robert D. Grove (U. S. Bureau of the Census, Washington, 1943).

²Yerushalmy, Jacob, Carroll E. Palmer, and Morton Kramer. *Studies in Childbirth Mortality II. Age and parity as factors in puerperal fatality*. Public Health Reports, Vol. 55, No. 27 (July 5, 1940), pp. 1195-1220.

³Deaths from Puerperal Causes by Race and by State; United States, 1943. Bureau of the Census, *Vital Statistics Special Reports*, Vol. 21, No. 5.

⁴Proceedings of Conference on Better Care for Mothers and Babies, Washington, D. C., Jan. 17-18, 1938, p. 146. Children's Bureau Publication No. 246.

⁵The rapid changes in the birth rates during 1942 and 1943 have not been considered in the calculation of the infant mortality rates used here. For discussion of this factor see "Effect of Changing Birth Rates Upon Infant Mortality Rates," by Iwao M. Moriyama and Thomas N. E. Greville, in *Vital Statistics—Special Reports*, Vol. 19, No. 21 (Bureau of the Census, Department of Commerce, Washington), and the very brief note in "Maternal and Infant Mortality in the U. S., 1942," by Marjorie Gooch, *The Child*, Vol. 8, pp. 179-185 (June 1944).

TABLE 7.—CAUSES OF DEATH IN THE FIRST YEAR OF LIFE; UNITED STATES, 1943 AND 1942

Cause of death	Deaths in the first year of life			
	Number		Number per 1,000 live births	
	1943	1942	1943	1942
All causes.....	118,484	113,492	40.4	40.4
Prenatal and natal causes.....	70,680	69,918	24.1	24.9
Premature birth.....	34,563	34,504	11.8	12.3
Congenital malformations.....	14,435	13,672	4.9	4.9
Injury at birth.....	10,990	11,455	3.7	4.1
Congenital debility.....	2,738	2,738	0.9	0.9
Other diseases peculiar to the first year of life.....	7,215	6,704	2.5	2.4
Syphilis.....	739	845	0.3	0.3
Influenza and pneumonia.....	18,207	16,144	6.2	5.7
Dysentery, diarrhea and enteritis.....	9,756	8,694	3.3	3.1
Epidemic and other communicable diseases ¹	3,685	2,952	1.3	1.1
All other definite causes.....	11,178	10,527	3.8	3.7
Ill-defined and unknown causes.....	4,978	5,257	1.7	1.9

¹ Measles, scarlet fever, whooping cough, diphtheria, cerebrospinal (meningococcus) meningitis, and tuberculosis.

TABLE 8.—INFANT MORTALITY; UNITED STATES AND EACH STATE, 1943 AND 1942¹

Area	1943		1942		Area	1943		1942	
	Number of infant deaths ²	Rate (deaths per 1,000 live births)	Number of infant deaths ²	Rate (deaths per 1,000 live births)		Number of infant deaths ²	Rate (deaths per 1,000 live births)	Number of infant deaths ²	Rate (deaths per 1,000 live births)
United States....	118,484	40.4	113,492	40.4	Montana.....	442	38.7	395	33.7
Alabama.....	3,477	44.8	3,561	50.1	Nebraska.....	889	35.5	791	33.4
Arizona.....	1,097	78.7	1,014	80.1	Nevada.....	158	52.2	159	57.2
Arkansas.....	1,594	37.4	1,694	39.7	New Hampshire.....	432	46.1	329	35.9
California.....	5,999	34.4	5,385	34.8	New Jersey.....	2,796	33.7	2,542	31.1
Colorado.....	1,228	50.4	1,172	49.7	New Mexico.....	1,394	91.6	1,383	97.9
Connecticut.....	1,162	29.8	1,088	29.2	New York.....	8,126	32.7	7,814	31.9
Delaware.....	291	46.7	266	47.0	North Carolina.....	4,416	46.7	4,342	48.3
District of Columbia.....	765	47.6	771	50.8	North Dakota.....	468	34.9	488	36.5
Florida.....	2,181	46.7	1,953	47.7	Ohio.....	5,640	39.1	5,345	37.0
Georgia.....	3,656	46.6	3,571	49.3	Oklahoma.....	2,068	42.5	1,906	41.4
Idaho.....	396	32.0	415	36.2	Oregon.....	763	30.0	687	30.5
Illinois.....	5,184	33.3	5,170	33.1	Pennsylvania.....	7,551	37.9	7,527	38.2
Indiana.....	2,960	39.6	2,701	36.6	Rhode Island.....	638	43.5	560	39.5
Iowa.....	1,618	34.0	1,623	33.5	South Carolina.....	2,985	55.1	2,866	58.7
Kansas.....	1,212	33.6	1,205	35.5	South Dakota.....	457	35.7	474	38.2
Kentucky.....	3,280	50.0	3,209	48.4	Tennessee.....	3,143	44.8	3,020	46.4
Louisiana.....	2,773	44.7	2,802	48.2	Texas.....	8,454	51.4	7,760	53.6
Maine.....	972	51.3	816	46.1	Utah.....	539	31.4	522	33.0
Maryland.....	2,037	43.0	1,941	43.9	Vermont.....	285	39.0	299	41.7
Massachusetts.....	2,939	34.2	2,651	32.0	Virginia.....	3,395	47.1	3,565	52.5
Michigan.....	4,813	38.3	4,608	37.2	Washington.....	1,550	34.8	1,292	33.1
Minnesota.....	1,809	30.9	1,739	29.6	West Virginia.....	2,261	52.1	2,329	53.0
Mississippi.....	2,800	46.8	2,680	47.3	Wisconsin.....	2,257	35.0	2,050	32.0
Missouri.....	2,918	40.3	2,761	39.0	Wyoming.....	216	37.1	251	45.1

¹ Tabulations are by place of residence.

² Deaths under 1 year, exclusive of stillbirths.

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CHILDREN AROUND THE WORLD

FRANCE

Legislation on juvenile delinquency

The alarming increase in juvenile delinquency in France in the years 1940-1944 has impelled the Provisional Government of that country to take new measures for dealing with the problem. A special procedure was introduced by a law of 1942 for hearing cases of young persons accused of illegal acts; and penalties were replaced by educational or corrective measures. This law was considered satisfactory in the beginning, but its defects, gradually discovered during the 30 years of its administration, and the recent progress in psychology and child training have shown the need for better methods of treating juvenile delinquency. To bring about such an improvement is the aim of a decree of February 2, 1945.

Juvenile courts under the decree of February 2, 1945

Under the law of 1912 children's cases were heard in courts of first instance, in addition to those of adults, but separately from them. The new decree provides for a separate juvenile court in each court of first instance. Each juvenile court is to be presided over by a "children's judge" selected from among the judges of the court of first instance and appointed for 3 years. The children's judge is to be assisted in hearing cases by two men or women active in child-welfare work, called assessors. These also are appointed for 3 years. Two substitute assessors must also be attached to the court.

Juvenile courts with a large number of cases may have two or more judges. The juvenile court in Paris, which also serves the surrounding territory of the Department of the Seine and to which are referred more than one-half of the cases of juvenile delinquency in the whole of France, is to have a presiding judge and a vice-president.

Field of jurisdiction of the juvenile court

As under the old law, the special methods prescribed by the decree of 1945 for treating juvenile delinquency apply to persons under 18 years of age accused of crimes or misdemeanors. Protective, educational, or corrective measures alone are permitted; penalties are applicable only in exceptional cases.

Procedure

In order to simplify procedure the present decree authorizes the children's judge to investigate cases of apparently minor offenses. The judge may decide alone in such a case, without referring to the juvenile court as a whole. During such an investigation the child is to be placed in an observation center instead of a police detention station, as was the custom in the past.

The judge may also order an investigation in any other case. The investigation is to include a study of the child's personality, the record of his school attendance, a physical and a psychological examination, and information about his family. The investigation is to be made preferably by trained social workers.

Before deciding on a case, the court hears the child, his parents or guardian, other witnesses, the public prosecutor, and the defense attorney. The child may be excused from appearing in court; he is then represented by his father, mother, or guardian, or by a lawyer.

The hearings and discussions at the court are closed to the general public, and publication in books, the press, motion pictures, the radio, or in any other way is prohibited. Fines are prescribed for violations of this provision.

If the court decides that the child has committed no punishable act, it dismisses the case. Otherwise, it may take any of the following measures:

1. Admonish the child;
2. Return the child to his parents, guardian, or other person who had been caring for him;

3. Place the child with a suitable family or individual, in a public or private welfare agency, or in an institution, whether educational, medico-educational, or one for vocational training, or for general care.

Probation

Probation is now given a more important place than heretofore. Whereas the law of 1912 made no mention of trained social workers serving as salaried probation officers, the present decree provides for the employment of such workers and for the regulation of their employment. As heretofore, the employment of volunteers is permitted; but experience in child welfare is emphasized. All persons engaged in probation and attached to one court are to work under the direction of a trained probation officer.

In the cases in which the court prescribes protective, educational, or rehabilitation measures, it may order probation as a supplementary measure, to be continued not later than the date on which the young person reaches the age of 21.

The probation officer is required to report to the judge the progress of the case, particularly any difficulties that may arise in the young person's conduct or environment; he may also suggest changes in the care of the child. Lack of proper supervision by a parent or guardian is punishable by a fine.

One year after the child has been removed from his family by court decision, the parents, guardian, or the child himself may ask for his return to the family; the request must be accompanied by evidence of the parents' or guardian's ability to take proper care of the child and of sufficient improvement on the part of the child.

Every person, agency, or institution offering to care regularly for children or young persons in compliance with the present decree must receive permission from the prefect of the department (administrative division of the French territory). Conditions to be specified in a subsequent decree must be met in order to receive this permission.

SOURCE: *Journal Officiel de la République Française*, February 4, 1945.

Anna Kalet Smith

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